STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Colorado

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge: Deduct.	Coins.	Copay	Amount and Basis for Determination
a. Hospital outpatient visit			x	$3.00 per visit
b. Physician home or office visit (M.D. or D.O.)			x	$2.00 per visit
c. Clinic visit (Rural Health, FQHC, and Public Health)			x	$2.00 per visit
d. Brief, individual, group, and partial care community mental health center visits (except services which fall under Home and Community Based Service programs)			x	$2.00 per visit
e. Pharmacy			x	$1.00 per prescription or refill for generic or multi-source drugs
			x	$3.00 per prescription or refill for single-source or brand name drugs
f. Optometrist visit			x	$2.00 per visit
g. Podiatrist visit			x	$2.00 per visit
h. Inpatient hospital visit			x	$10.00 per day
i. Psychiatric services			x	$ .50 per unit of service (defined as 15 minute segments)
j. Durable medical equipment / supplies			x	$1.00 per date of service
k. Laboratory services			x	$1.00 per date of service
l. Radiology services			x	$1.00 per date of service

When the average or typical State payments for the above services are taken into consideration, all copayments were computed at a level to maximize the effectiveness without causing undue hardship on the recipients, assuring that they do not exceed the maximum permitted under 42 CFR 447.54.

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A (h.) Inpatient hospital visit (cont.)

An inpatient hospital copayment charge cannot exceed 50 percent of the payment the agency makes for the first day of care in the institution. The system has been coded to calculate the copayment at the lesser of $10 per covered day or 50% of the average allowable daily rate.

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B. The method used to collect cost sharing charges for categorically needy individuals:

☒ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for a services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

The copayment is collected at the time of service, according to state statute. The recipient may indicate his/her inability to pay at that time. Inability to make a copayment at the time of service characterizes the recipient's immediate financial situation. The provider may not deny services to a recipient who may be unable to pay although this does not extinguish the liability of the recipient.

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D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

Providers are notified of copayment requirements for services covered and exempt groups and services through Medicaid bulletins issued by the fiscal agent. Providers are required to assess copayment at the time of service delivery. Amendments to section 1916(c) of the Social Security Act include a provision that no provider participating in Medicaid may deny care or services to an individual because of his/her inability to pay the required cost sharing charges. An individual who is unable to pay the copayment will self-declare the inability to pay, and the provider will be required to provide the services. The recipient is still responsible for the copayment and the provider may collect at a later date.

E. Cumulative maximums on charges:

☒ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below: